

<b>Case Number:</b>	CM13-0036688		
<b>Date Assigned:</b>	12/13/2013	<b>Date of Injury:</b>	11/08/2010
<b>Decision Date:</b>	04/23/2014	<b>UR Denial Date:</b>	10/14/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/21/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Medicine, and is licensed to practice in Florida. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a 60-year-old female who reported an injury on 11/08/2010. The mechanism of injury was repetitive work. The patient was noted to be treated with chiropractic care, acupuncture and physiotherapy. The patient underwent an MRI in 2011. The documentation of Final Determination Letter for IMR Case Number [REDACTED] 3 08/07/2013 revealed that the patient had complaints of right shoulder pain, which was rated at a 7/10. The patient had slight to moderate tenderness upon palpation of the right shoulder, and the range of motion was decreased by 35%. The patient had a positive Yergason's and a positive Apley's scratch test. Additionally, it was noted that there were discrepancies in sensory and reflex. Flexion and extension revealed pain and discomfort. There were discrepancies in the girth measurements of the upper extremities. The patient's diagnosis was noted to be subacute, traumatic moderate right shoulder sprain/strain radiating to the cervical spine, rule out ligamentous injury. The request was made for chiropractic care, to include manipulation and myofascial exercise to the right shoulder at 3 times a week for 4 weeks, physiotherapy and acupuncture as well as a work hardening program, a Functional Capacity Evaluation, a TENS unit and an MRI.

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

**ACUPUNCTURE (2 TIMES PER WEEK FOR 4 WEEKS): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** The MTUS Acupuncture Guidelines indicate that acupuncture is used as an option when pain medication is reduced or not tolerated and is recommended as an adjunct to physical rehabilitation. The time to produce functional improvement is 3 to 6 treatments, and acupuncture treatments may be extended if functional improvement is documented, including either a clinically significant improvement in activities of daily living or a reduction in work restrictions. The clinical documentation submitted for review indicated that the patient had prior acupuncture treatments. However, there was a lack of documentation indicating the quantity and the patient's functional benefit that was received. The request as submitted failed to indicate the body part that was to be treated. There was a lack of documentation indicating that the patient would be utilizing acupuncture as an adjunct to physical rehabilitation. Given the above, the request for acupuncture 2 times per week for 4 weeks is not medically necessary.

**CHIROPRACTIC CARE (2 TIMES PER WEEK FOR 4 WEEKS):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58-60.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation and the Official Disability Guidelines (ODG), Shoulder chapter. Pa.

**Decision rationale:** The MTUS Chronic Pain Guidelines recommend manual therapy for chronic pain if it is caused by musculoskeletal conditions. However, they do not address manual therapy for the shoulder. As such, secondary guidelines were sought. Per the Official Disability Guidelines, the treatment for sprains/strains of the shoulder and upper arm is a recommended 9 visits over 8 weeks. However, the clinical documentation submitted for review indicated that the patient had prior chiropractic care. There was a lack of documentation indicating the quantity of sessions that the patient had attended, and the patient's functional benefit that was received. The request as submitted failed to indicate the body part that was to be treated. Given the above, the request for chiropractic care 2 times per week for 4 weeks is not medically necessary and appropriate.

**TENS UNIT:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 114-117.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 115-116.

**Decision rationale:** The MTUS Chronic Pain Guidelines recommend a one month trial of a TENS unit as an adjunct to a program of evidence-based functional restoration for chronic neuropathic pain. Prior to the trial there must be documentation of at least three months of pain and evidence that other appropriate pain modalities have been tried (including medication) and

have failed. The clinical documentation submitted for review failed to indicate that the patient had neuropathic pain. Additionally, there was a lack of documentation indicating that the patient had trialed and failed other appropriate pain modalities, including medications. The request as submitted failed to indicate the duration for the use of the unit. It failed to indicate whether the unit was for purchase or rental. Given the above, the request for a TENS unit is not medically necessary and appropriate.

**MRI OF THE RIGHT SHOULDER: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-9.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder chapter section on MRI

**Decision rationale:** The Official Disability Guidelines do not recommend repeat MRIs unless the patient has a significant change in symptoms and/or findings suggestive of a significant pathology. The patient underwent an MRI in 2011. The clinical documentation submitted for review failed to provide documentation of prior examinations to indicate that this was a significant change or findings suggestive of a significant pathology that was not chronic in nature. Given the above, the request for an MRI of the right shoulder is not medically necessary.